| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155661 | A. BUILDING _____ B. WING _____ | R-C 12/23/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| OWEN VALLEY HEALTH CAMPUS | 920 W HWY 46 SPENCER, IN 47460 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 000} | INITIAL COMMENTS | {F 000} | | |

This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00138997 completed 11/05/13.

Complaint IN00138997 corrected.

Survey dates: December 20 and 23, 2013

Facility number: 010892
Provider number: 155661
AIM number: 200229560

Survey team:
Susan Worsham, RN-TC
Cheryl Mabry, RN
(12/23/2013)

Census bed type:
SNF: 10
SNF/NF: 84
Total: 94

Census payor type:
Medicare: 13
Medicaid: 69
Other: 12
Total: 94

Sample: 03

Owen Valley Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the Investigation of Complaint IN00138997.

Quality review completed on December 27, 2013; by Kimberly Perigo, RN.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155661 | A. BUILDING _____ B. WING _____ | R-C 12/23/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| OWEN VALLEY HEALTH CAMPUS | 920 W HWY 46 SPENCER, IN 47460 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | | |